MANAGED HEALTH CARE IMPROVEMENT TASK FORCE
OCTOBER 10, 1997 REGULAR BUSINESS MEETING MINUTES

Adopted by the Task Force on October 28, 1997

Friday October 10, 1997
8:30 AM
Imagine That! Conference Facility
1318 West Ninth Street
Upland, California

I. CALL TO ORDER [Chairman Alain Enthoven, Ph.D.] - 8:45 AM

The fifth business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by Chairman, Dr. Alain Enthoven, at the Imagine That! Conference Facility in Upland, California.

II. OPENING REMARKS [Chairman Enthoven] - 8:46AM

Chairman Enthoven began the meeting by summarizing the day's agenda. Specifically, he stated that the five papers listed on the agenda were scheduled for discussion only, and he reiterated that these papers would be scheduled for a vote at a subsequent meeting. The only vote that would be taken at this meeting would be a vote to adopt the amended meeting schedule to include additional meeting dates. Chairman Enthoven asked that, in keeping with the tight agenda for the day, all comments on the five papers be as concise as possible, including comments that the public might wish to make. Chairman Enthoven also encouraged members to submit any comments on the papers to him in writing.

He also briefly addressed a question that had been raised by several Task Force members regarding the ownership of the ERG [expert resource group] papers. He stated that ultimaltey the documents will be Task Force papers and not the papers of any individual authors. He also said that at this point, the papers have had the "ambiguous status" of being joint products of the ERG members and the Chairman and his staff. He clarified that the Executive Director's role in the papers would now increase substantially.

III. ROLL CALL AND DECLARATION OF A QUORUM - 8:59 AM

Chairman Enthoven asked Ms. Stephanie Kauss to take roll, and she compiled. The following Task Force members indicated they were present: Dr. Bernard Alpert, Ms. Rebecca Bowne, Ms. Barbara Decker, Dr. Alain Enthoven, Ms. Jeanne Finberg, Dr. Bradley Gilbert, Ms. Diane Griffiths, Dr. Michael Karpf, Mr. Peter Lee, Dr. J.D. Northway, Ms. Maryann O'Sullivan, Dr. Helen Rodriguez-Trias, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. Steve Zatkin. Hn. Martin Gallegos, Mr. Mark Hiepler, Mr. Anthony Rodgers, and Mr. Terry Hartshorn arrived after roll call.

The following Ex-Officio members were also present: Ms. Kim Belshe, Mr. Michael Shapiro, and Ms. Marjorie Berte.

A. Executive Director's Report [Dr. Phil Romero] - 9:00 AM

Executive Director Romero strongly endorsed the comments made by Chairman Enthoven. He also stressed that all papers, the five being discussed on today and all future papers,

would be available on the Task Force's Internet Web page **[www.chipp.cahwnet.gov/mctf/front.htm].**

IV. NEW BUSINESS - 9:05 AM

A. Amendments to Task Force Meeting Schedule – 9:05 AM

Chairman Enthoven introduced the first order of business as the discussion and adoption of amendments to the Task Force meeting schedule. Chairman Enthoven asked Deputy Director Alice Singh to summarize the amendments. Ms. Singh indicated that the proposed amendments would allow the Chair to call up to three additional meetings on a "as needed" basis. After some discussion, Mr. Lee moved to adopt the amended meeting schedule with the following additional amendment: that the October 29 meeting date be eliminated. Ms. Severoni seconded the motion and it was adopted unanimously. After Mr. Zatkin indicated that December 15th would not be an acceptable meeting date for him, Chairman Enthoven took an informal poll on this issue. Seeing that a December 13th meeting date was more conducive, Mr. Lee moved that the meeting schedule be amended to change the December 13th meeting to December 15th. Ms. Bowne seconded the motion, and it was unanimously adopted.

Ms. O'Sullivan wanted to confirm that time would be set aside for public comment after Task Force discussion on each paper. Chairman Enthoven confirmed that time would be made available and encouraged members of the public to keep their comments concise.

Ms. Finberg asked about the public availability of the EGR papers. Ms. Singh reiterated that all papers are made available to the public once they have been mailed out to the Task Force members. To increase accessibility, the papers will and are made available on the Task Force Internet Web page.

Mr. Lee commented briefly on the outline of the January 1 report, which he wanted to confirm was a working draft only. He also suggested that the report contain a section dedicated to both the public testimony obtained during Task Force public hearings and the results of the public survey. He also stressed the importance of cataloging public testimony and information as received by the Task Force and including this information in the report as an appendix.

B. Discussion of the Health Industry Profile ERG Paper – 9:20 AM

Margaret Laws, a member of the Stanford staff, presented the Health Industry Profile paper. She gave a brief overview, quickly running through the sections of the document, and then asked for comments and changes from the members.

The Health Industry Profile paper provides background (as required in the Task Force authorizing legislation) on the history of managed care. It includes a brief look at the fee-for-service system that preceded it, the passage of the HMO Act in 1973, the cost pressures that forced the spread of managed care in the 80's, and the current regulatory environment. The paper also contains a description of major industry terms, trends and structures. Finally, the paper discusses the area of tax status and the shift from not-for-profit to for-profit status.

After Ms Laws' overview, members had an opportunity to discuss and suggest changes to the paper. Dr. Northway began the discussion by suggesting that the paper be revised to include a discussion of trends in the number of uninsured persons and any relationship between that trend and the rise in managed care. He was particularly concerned with the increased number of

uninsured persons despite the current low unemployment rate. Dr. Alpert pointed out that one of the hopes of managed care was that it would provide a "dividend" that might ameliorate the problem of the uninsured. Mr. Williams suggested that the Task Force be mindful of the degree to which its actions either increase or decrease the severity of the problem. Ms. O'Sullivan requested that the paper discuss the impact of managed care on providers' willingness to provide charity care.

Mr. Lee made two suggestions: the paper should include 1) more information about the growing importance of medical groups and 2) a more complete description of the fee-for-service system, particularly regarding quality assurance mechanisms, so as not to create a "straw man".

Regarding Mr. Lee's first point, Dr. Gilbert suggested that the paper include a discussion of the changing physician practice and the growth of integrated medical groups and IPAs. Ms. Decker asked that the paper describe the growing trend of health plans delegating authority to medical groups. Dr. Spurlock requested that the paper include a substantive discussion about the different ways medical groups are managed. Mr. Williams suggested the paper comment on the role of medical groups in clinical quality management processes and customer service.

Regarding Mr. Lee's second point, other members thought that the papers should focus on presenting an accurate description of and suggesting improvements to managed care, rather than comparing managed care to fee-for-service. Ms. Severoni suggested that the principles and values that guide both managed care and fee-for-service be included as a starting point in the discussion. For example, there has been a shift from focusing on the care of individuals to the care of populations. Ms. Griffiths suggested that the paper should provide more evidence to support its arguments, particularly regarding criticisms of fee-for-service. Mr. Lee suggested that the paper should make more comparisons among types of managed care organizations. Dr. Rodriguez-Trias suggested that managed care be evaluated in terms of how well it meets the health care needs of the population, rather than comparing it to the fee-for-service system.

Ms. Finberg suggested that the paper should describe the industry from the consumer point of view, especially in terms of system navigation, access, and accountability. Mr. Williams further commented that the paper should discuss the tradeoffs to consumers when they move from one type of health plan to another. He also requested more data on trends in the percentage of medical expenditures paid by consumers, including a discussion of the difference between deductibles and co-payments.

Mr. Gallegos commented on a section of the paper that he felt had a strong negative slant regarding the physician in the fee-for-service system. He felt that some of the statements in the paper imply that the doctors working in the fee-for-service system were motivated by economics and not by the practice of good quality medicine. He asked that this particular section be omitted or at least made more balanced. Ms. O'Sullivan also asked for some added clarification or balance to the discussion of mental health benefits. Dr. Alpert discussed "spin" and the need to portray both sides of the issues. Ms. Griffiths suggested that where statements are controversial, they be identified as beliefs of a particular group rather than portrayed as a matter of fact.

Other suggestions included:

- Add a discussion of national trends that influence managed care structures in California. For example, discuss the move towards standardization of benefit packages, changes in HCFA regulation and financing, etc. (Dr. Rodriguez-Trias)

- Expand and balance the discussion of excess capacity in physician and hospital bed supply. (Dr. Spurlock)
- Add a discussion of Medi-Cal managed care. (Ms. O'Sullivan)
- Clarify and strengthen the discussion of ERISA. (Mr. Hiepler)
- Broaden and balance the discussion of tax status, particularly the consequences of the movement towards for-profit medicine. (Mr. Shapiro)
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PUBLIC COMMENT – 10:20 AM

1) **Richard Van Horn** – President, California Coalition for Mental Health – He asked that the Health Industry Profile paper be amended to indicate that there are some very different views on just how available the care for the mentally ill really is. He asserted that private mental health programs are less accessible than the public system and that the private system is cost shifting onto the public sector. He offered to produce documentation regarding this issue, which Chairman Enthoven asked him to forward to the Task Force.

2) **Verah Mthombeni** – , Loma Linda Child Adolescent Medical Clinic – Ms. Mthombeni requested that HMOs have qualified personnel in related fields making the decisions needed for the patients. She asserted that IPAs have the power to manipulate their physicians' patient lists without the physicians' knowledge. She pointed out that IPAs do not have appropriate specialists in all fields.

Break – 10:40 am

C. Discussion of the Impact of Managed Care on Quality, Access and Cost ERG Paper – 11:00 AM

Chairman Enthoven introduced Sara Singer, a member of the Stanford staff, who presented the second ERG paper, The Impact of Managed Care on Quality, Access and Cost.

Executive Director Romero had a few comments to make before the discussion of the second ERG paper began. He wanted to comment on the issues of spin or comparison that were discussed regarding the first paper. He put a question to the Task Force members: "If we don't compare managed care to fee-for-service, what do we compare it to?" The members responded that the comparison between these two systems was unavoidable, but it had to be written and presented in an unbiased way to the greatest extent possible. Also, several members stressed that there are systems, standards and measurements that can be used as additional comparison tools between managed care and fee-for-service (e.g., Healthy People 2000, HEDIS).

Ms. Singer summarized the second ERG paper. With regard to quality, she summarized that outcomes are highly dependent on the organization and the disease. She highlighted positive and negative findings about managed care quality. With regard to cost, the paper concluded that California generally has a lower cost structure than the nation as a whole. With regard to access, the paper discussed tradeoffs. For example, managed care entails better access in terms of cost and some services, but worse access in terms of doctor and referral restrictions. She pointed out that there are some concerns that cost containment is leading to problems in quality.

Dr. Alpert began the discussion by questioning a statement in the paper's Executive Summary that asserted that managed care has likely improved access by preventing more people from becoming uninsured. He felt that it was a speculative sentence that was not backed up with evidence. Ms. O'Sullivan stated her concern that people actually have poorer access under managed care. Mr.

Zatkin described a Congressional Budget Office study that looked at this issue, which Chairman Enthoven said he would get.

Mr. Lee asked that section G of the paper be deleted because it recommendations. He felt that potential solutions should arise from the discussion between the members and should not be listed in the papers. The members agreed to omit section G. Mr. Zatkin agreed with Mr. Lee's recommendation and stated that all the ERG papers should remain background papers only.

Dr. Spurlock stated his belief that a lot of the concerns related to managed care quality are based on perception rather than reality. He requested that the paper discuss and highlight the tension of trying to look at population health measures from an individual perspective.

Dr. Rodriguez-Trias wanted to add to the paper a discussion of the cost to the consumer, as opposed to system costs. She also wanted to make sure that a discussion of this issue would not make HMOs synonymous with managed care.

Ms. O'Sullivan had some major concerns about this paper. She felt the paper was written to make managed care look great. She wanted the paper to be completely rewritten in a more concise, factual, objective way. Ms. Bowne felt the paper was well written with very valuable information. She stated that there were certain sections that could be more balanced, but as a whole it was a very good background paper. Mr. Lee thought that the paper should be more balanced rather than shorter and he also felt that the paper needed to discuss a broader range of public perception.

A discussion ensued by several members as to whether the papers should be more concise, which could help cut down on the balance and controversy issues, or whether they should remain as they are. Mr. Gallegos suggested that the Task Force consult with the author of the legislation (Assembly Member Richter) to determine what the intent of the legislation really is regarding the reports.

Many of the members felt that the executive summaries of the papers would be, realistically, what people would read of the papers. They wanted to make sure that all the data in the papers was included in some way in the summaries, so that people can make the same conclusions even if they didn't read the complete paper.

Both Dr. Gilbert and Mr. Zatkin asked that specific references to HMOs be omitted from the papers. All plans should be referred to in generic terms.

Ms. Severoni thought the paper should recommend that information about quality be presented in a way that is meaningful to consumers. She further stated that while costs may have decreased, the public very strongly believes that they are paying more. She recommended that employers periodically include in their employees' pay stub what their health care contribution is. Ms. Finberg further requested that the quality and access sections, in addition to the cost section, be expanded from the consumer perspective.

PUBLIC COMMENT - 11:53 AM

1) **Richard Van Horn**, President, California Coalition for Mental Health. Mr. Van Horn asked the Task Force to recommend passage of AB 1100, a mental health parity bill.

2) **Mariana Lamb**, Director, Medical Oncology Association of Southern California. Ms. Lamb cautioned the Task Force against shortening the papers, especially when discussing quality,

access, and cost. She felt the members would lose the focus and the intent of the papers by shortening them.

Lunch Break – 12:05 pm

Upon reconvening after lunch, Chairman Enthoven said that without objection, he would move to the discussion of the Risk Adjustment paper instead of the Balancing Public and Private Sector Roles paper. Seeing no objection, Chairman Enthoven moved to the Risk Adjustment Paper.

E. Discussion of the Risk Adjustment Paper – 12:20 PM

Chairman Enthoven began the discussion by commenting that there are many reasons for risk adjustment. One is to give consumers a level playing field and give them a fair economic choice of a wide access product. Another is concerns over fairness and leaving out large portions of the population ("skimming").

Mr. Zatkin responded that he is in favor of risk adjustment and its ability to help create a better system. He also wanted to know if the risk adjustment technology was available and accepted for hospitals as opposed to medical groups. Dr. Spurlock added that he felt a recommendation by the members was needed to encourage further research regarding the technology of risk adjustment.

A discussion was held regarding the difference is this paper compared to the previous two that were discussed. Mr. Lee felt this paper was more of a recommendation paper rather than a background paper and it needed to be stated as such.

Ms. Griffiths raised the issue of patients' right to privacy around the information sharing that would be required with risk adjusting. Chairman Enthoven thought that the technology was in place so that when a patient transfers their information it is re-coded in such a way so that it is not possible to identify the individual. Mr. Williams expanded on this issue, asking the members to really understand the data limitations in terms of coding and methodology. He also felt it is important to grasp the difference between Medicare populations and the commercial populations. He suggested that the Task Force explore other options such as stop-loss insurance and enrollment protection.

Ms. Bowne expressed some major concerns with the paper and some of its recommendations. She felt that risk adjustment is a good idea but she strongly cautioned members to get the facts straight before plunging in and possibly mandating everyone to do it. Dr. Karpf agreed, but he added that a consensus needs to be reached as to what system is going to be used and to see that it is used in a uniform way.

Mr. Hartshorn wanted assurances that the risk adjustment process would be cost neutral to individual consumers, as much as possible.

The members discussed the recommendations that were expressed in the executive summary of the papers. They discussed, revised and changed several of the recommendations. In general, they wanted an approach of first recommending a certain course of action and then requiring it after a certain time period. They recommended that major purchasers and foundations should support the development of appropriate research and development in risk adjustment. They also recommended that CalPERS report back to the legislature in a certain period of time on what they have done to implement risk adjustment. The third recommendation called for the Department of Health Services to join with HCFA in a project exploring risk adjustment in plans serving Medi-Cal

beneficiaries. Several of the changes that the members suggested included revision of some of the words and expressions used in the recommendations. They also revised several of the timelines set forth in the recommendations.

Break – 1:55 PM

Upon reconvening from the break, Chairman Enthoven stated that without objection, he would move to the Expert Resource Group oral reports as opposed to finishing the remaining two ERG papers. Seeing no objection, Chairman Enthoven moved to the ERG Reports.

V. EXPERT RESOURCE GROUP REPORTS AND DISCUSSIONS - 2:15 PM

A. Doctor-Patient Relationship [Members Gilbert, Hiepler, Perez]

Dr. Gilbert began the discussion with an overview of what his ERG did in preparation of this presentation. First, they incorporated as much information as possible about physician-patient relationships. They tried to add all the information that was presented by the public at all the public hearings. Second, they did a semi-intensive review of the literature regarding this issue. Third, they conducted a hearing with all three ERG members. Members of the public testified at that hearing. Lastly, they spent a lot of time with primary care doctors, talking to them and gathering information. Using all this gathered data, they have identified areas of concern in the physician-patient relationship relating to managed care. They presented their initial recommendations to the other members.

In the area of continuity of care, they first recommended that health plans and medical groups be required make contractual arrangements that allow patients, or a subset of patients, to continue seeing their doctors until the end of the contract year. They next recommended that plans be required to disclose the PCP's, medical groups, IPAs, and specialists available and their access limitations. Third, they recommended that plans be required to give reasons when they terminate providers.

Under quality improvement, they recommended streamlining physician audits and making a standard audit to be used throughout the industry. They also recommended improvements in consumer information.

Mr. Hiepler continued with the overview. He suggested eliminating prior authorization requirements for specialty visits. He felt this would force HMOs to do a better job of selecting their primary care physicians, cut down on malpractice claims, allow doctors to practice their specialty, and reduce the frustration level of both doctor and patients. The ERG recommended a more modest approach of setting a time limit by which a primary care physician can earn a "gold card" exempting them from prior authorization requirements. They also recommended requiring explanations for referral denials, disclosure of the basis for medical necessity decisions, disclosure of who made the denial decision, and disclosure of financial incentives.

Dr. Gilbert also touched upon several other areas that their group had studied, including physician and appointment availability, physician standards, and supervision and oversight of physician extenders.

After their presentation members had an opportunity to comment and discuss their recommendations and suggestions. Both Ms. Bowne and Mr. Gallegos asked about the process that doctors could use once they had been terminated from a plan, including notifying the enrollees

of the pending termination. Mr. Hiepler stated that although logistically difficult, they recommend that a letter go out to all patients letting them know that their physician is being terminated and they have a certain amount to time to secure a new physician.

Mr. Shapiro commented on the idea of plans giving a "gold card" to physicians in their groups. He wanted to make sure that the physicians getting these cards were not referring patients to specialists because of the high cost to the HMO, or being pressed into denying care.

Chairman Enthoven spoke on the issue of financial incentives. He recommended that a pilot project be done in which randomly selected medical groups come up with a model statement regarding financial incentives and then present it to their members, asking for some feedback on the model and ultimately sharing the information with the legislature. Dr. Karpf mentioned that he would like this information regarding disclosures to be made available to the physicians as well.

Break – 3:55 PM

B. Academic Medical Centers and Health Care Workforce [Members Bowne, Karpf]

Dr. Karpf began the discussion with a description of a health center. He described a health center as an entity that consists of a school of medicine, a hospital and a variety of other services that provide health care to a number of patients. There are about 125 to 140 health centers and they have essentially three missions: education, research, and service. There are two types of service: high-end tertiary care and the safety net of health care. Health centers flourished in the 50's and 60's and then in the mid 80's the money for research and education dried up and the centers had to become much more accountable for health care costs. In order to resolve these cost issues and to help these centers survive, he felt the Task Force needed to take a look at what they provide for us and what is appropriate to support.

Because of the nature of the health center, they tend to draw the sickest, most critical patients. He stated that this issue needs to be recognized in the form of risk adjustment. He felt the surplus and maldistribution of physicians will need to be addressed. He stated that the cost of medical education is a growing problem. Dr. Karpf stated that it will become incumbent upon the state of California to study and analyze and understand what its medical educational needs are and if it is going to support the needs for the future. The last issue he discussed was the issue of how to ensure that society will allow and encourage academic health centers to continue to push the envelope of care and continue on with the evolution of medical knowledge.

Ms. Bowne spoke about the oversupply of physicians. She suggested that the State provide incentives for training of residents in managed care and ambulatory settings, particularly in under-served areas. Regarding research, she felt that the costs need to be shared by society as a whole because society does benefit from the results of the research.

The members now had a chance to ask questions and give comments on the presentation. Dr. Rodriguez-Trias asked about the incentivising and distribution of physicians on California. Dr. Karpf stated that there are benchmarks in California that continue to be met and reengineered to become better. Ms. Bowne remarked that the progress on this issue needs to be better documented and more available for study.

Mr. Rodgers asked about the mechanisms that could be used to better understand what is best for different regions of the state and how to make the medical centers successful and possibly integrated. He also suggested that the group draft some sort of a suggestion about how to

proportion the work force in an appropriate way. Dr. Karpf stated that medical centers are working hard to create relationships with other centers and merging with other hospitals in order to survive. He also suggested that in regards to paying for the education of medical research, he felt that an all payer system is appropriate.

PUBLIC COMMENT – 4:50 PM

1) **Teresa Bush-Zurn**, California Dietetic Association. Ms. Bush-Zurn asked the members to recommend that HMOs encourage the maintenance and expansion of the dietetic internship and educational process.

2) **Nell Woodward**, California Dietetic Association. Ms. Woodward asked the members to recommend that HMOs maintain and expand supervised practice studies of dietitians and technicians.

3) **Mary Ann Schultz**, American Nurses Association. Ms. Schultz asked the Task Force to consider working with the Nurses Association on specific issues. She volunteered her time to work on the Task Force on behalf of her organization.

Before the last two speakers were asked to comment, Chairman Enthoven wanted to make some brief remarks about the remainder of the meeting and the agendas for future meetings. He proposed to postpone until the next meeting the two ERG papers that were not discussed at this meeting, Standardization of Benefits and Balancing of Private and Public Sector Roles. He felt that the Balancing of Roles paper would need some additional work and would be re-sent to the members in a revised form. Because of the length of discussion of the papers and the amount of papers to be reviewed, he asked that members be aware of their demands for rewrites and revisions.

4) **Barbara Smith**, Orange County Managed Care Task Force. Ms. Smith described the organization and their mission, which arose from a Washington, D.C report on the vulnerable elderly. They recommend improved case management in the vulnerable elderly population and would like to consider risk adjustment for this group.

5) **Patti Strong** Service Center for Independent Living. Ms. Strong encouraged the Task Force to take a long-term view of its issues. She argued for good case management and the right to have good, quality care in the short run as well as in the long run.

VII. ADJOURNMENT - 5:35 PM

Chairman Enthoven declared that without objection, the business meeting would be adjourned. Seeing no objection, Chairman Enthoven adjourned the meeting.

Prepared by: Stepanie Kauss